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PIONEERING THE FUTURE

THE 1988 BROCK CHISHOLM MEMORIAL LECTURE

BY

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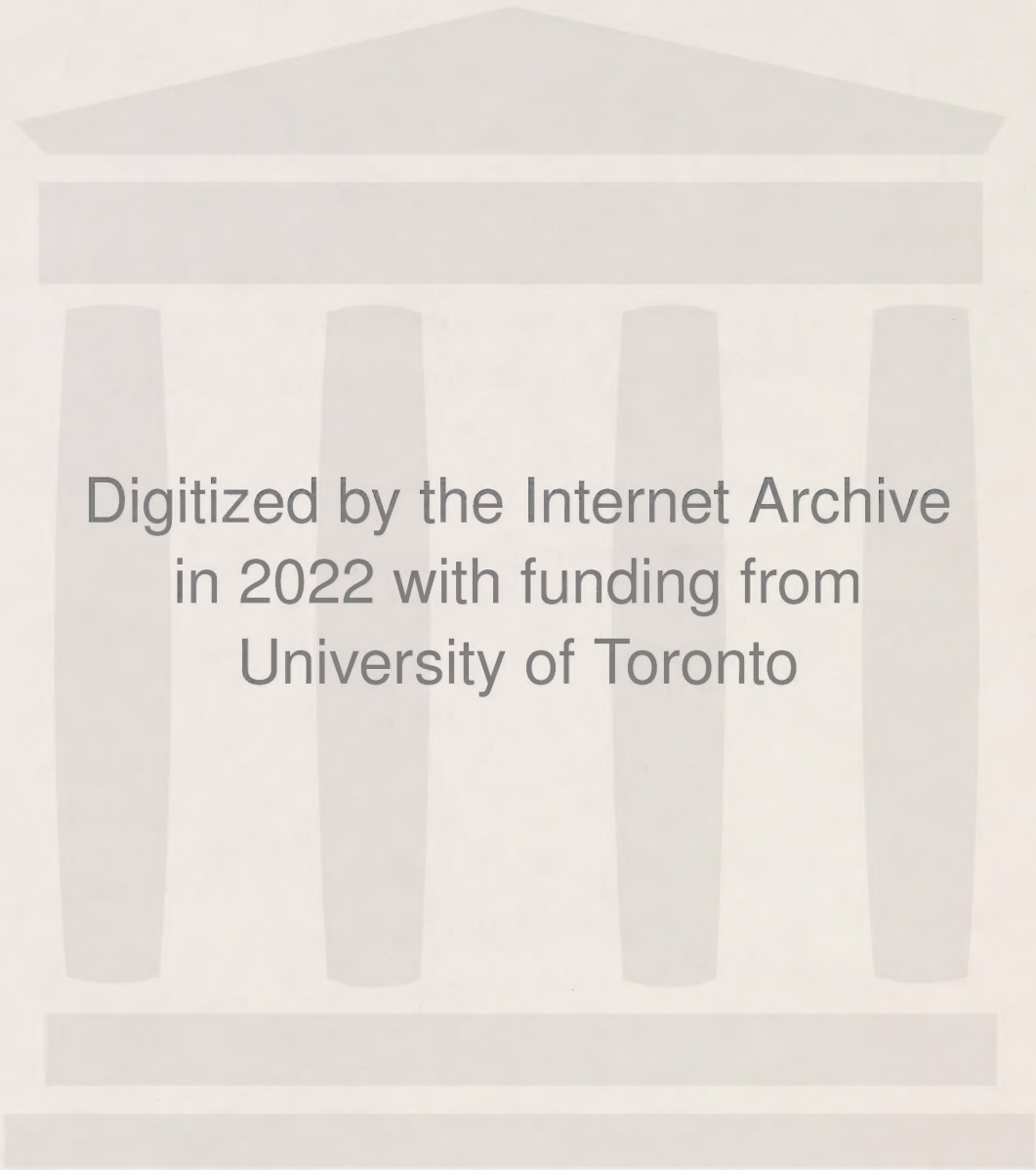

Fellow delegates, distinguished colleagues, ladies and gentlemen. I am deeply honoured by the opportunity to speak to you today, as we celebrate the fortieth anniversary of the World Health Organization and the memory of Dr. Brock Chisholm, a remarkable Canadian who served as the first director general of the WHO.

Dr. Chisholm was that rarest of individuals, the practical visionary, a man in possession of the skills and determination needed to build an ideal into a lasting reality.

During his own lifetime he was showered with forty-one separate honours and awards from universities, voluntary agencies and governments around the globe, for his profound contribution to world health. Today, seventeen years after his death, we continue to honour his memory.

In doing so we pay homage to a great statesman, a health pioneer, and an administrator whose skill in constructing a solid foundation for the work of world health is reflected in the continued and growing effectiveness of the World Health Organization.

But we also remember Brock Chisholm the humanist - a man with uncompromising ideas about the right of all people to live in health, in a clean environment and free from the threat of war.

It is this vision that continues to provoke and inspire us as we move toward the year 2000.

One of Dr. Chisholm's most durable legacies was his influence on the constitution of the World Health Organization itself. In particular, I am thinking of article one of that constitution, defining health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."

What a far-reaching definition that proved to be. It seems to me that, for the past forty years, governments around the world have been coming to terms with the broad medical and social agenda implied by this single conception of human health. In fact, with each passing year, the idea has become more influential and challenging, as our appreciation of its wisdom grows and we come to understand its implications for our mutual goal of achieving health for all by the year 2000.

This afternoon, I would like to share with you some aspects of Canada's experience in reaching a renewed understanding of the meaning of health as a resource for living. Then in the spirit of Dr. Chisholm's pioneering nature, I will take the liberty of discussing some of my personal reflections on the future.

Thirty years ago, when Canadians set out to create our present system of universal health insurance and access to medical care, the implications of the World Health Organization's definition of health were not totally apparent to us. At that time, we believed that a system providing equal access to medical and hospital treatment of illness for all our people, regardless of ability to pay, would enable everyone to achieve the same level of health.

Without a doubt, the creation of a universal system of Medicare was a major achievement for Canada - the fortuitous offspring of a marriage of affluent times and a rare unanimity of political will within our federal system of government.

On the whole, the system works, and works well. Canadians - who place a strong cultural value on health care and quality of life issues - continually rate medical services highly. Indeed, within Canada, support for universal access to health care, regardless of ability to pay, is now considered by many as an integral aspect of our national identity.

In the early 1970's, however, it became increasingly clear that equal access to the medical treatment of disease and infirmity did not equate with equal opportunities to achieve health itself. By 1974, that understanding was made public in the release of a national paper entitled A New Perspective on the Health of Canadians. This influential document described a systematic way of thinking about health in terms of human biology, environment, lifestyle, and health care organization.

Conventional wisdom has it that A New Perspective on the Health of Canadians had more immediate influence abroad than at home. Around the world it spurred the creation of a number of similar papers. In Canada, it led, among other things, to the creation of a government unit responsible for health promotion and a host of new programs designed to promote lifestyle change.

And so, when, as a member of the World Health Organization, we in Canada began to discuss the goal of achieving health for all, as defined at the World Health Assembly in 1980, the idea that better health meant reaching beyond the traditional medical model of cure and care was already well established.

The issue of equity, which is so central to the "achieving health for all" movement, is a case in point.

Canadian life expectancy statistics, though less dramatic than world figures, underscore the same universal social reality: those who are well off live longer and healthier lives than the poor.

So, even with an effective universal health care system in place, Canadian men with good incomes can expect to outlive their poor neighbours by an average of over six years. They will also enjoy an average of over fourteen more years of disability-free life. That's a difference of 29 per cent. Similarly, upper-income women in Canada will enjoy over eight more years of disability-free life than women who are less well off.

These are some of the measurable facts of inequity. The cold statistics. Other statistics tell us that in addition to socio-economic status, health in Canada is affected by a host of other social, environmental and demographic variables -- factors such as age, ethnicity, geographic location, employment status, discrimination and education levels.

Behind these numbers, studies have pointed to a complicated and often lifelong pattern among the poor and other vulnerable groups - a pattern of elevated levels of stress, a higher incidence of risk behaviour, increased alcohol, tobacco and drug use, uncontrolled hypertension, nutritional deficiencies, and many other problems that cannot be adequately addressed by better medical technology. In fact, the people who make the greatest use of our medical system are also those most likely to endure lives characterized by environments that lead to chronic low levels of health.

I would be remiss in a discussion about equity if I did not, once again, draw our attention to the global arena. In today's world, living conditions and inequalities in health, between and within countries, have been worsened by the economic recession of the early 80's, which led to increased unemployment, soaring inflation and unworkable debt burdens in many countries. For example:

- Half of the people in developing countries have no reasonable access to clean water or basic sanitation; most of the rural population have no access to basic medical care;

- All over the world, prejudice, violence, stress, overcrowding and disability are growing issues for populations that are aging, diversifying and migrating rapidly to the world's cities;

. Each week, more than one quarter of a million young children still die in the developing world, from infection and undernutrition.

While the gap between the developed and developing world remains our most formidable challenge, we are also aware that the poor, the illiterate, the homeless, the sick, and the hungry are not confined to developing nations. They exist in rich countries as well.

In the last decade, Canada has stepped up efforts to find an effective response to these and other problems, both at home and in the world beyond our national boundaries.

Gradually, a more comprehensive strategy has evolved. It is an approach that is based on a framework designed to promote health; an approach which, I believe, is in accordance with Dr. Chisholm's vision of health as a positive resource for everyday living.

This approach is described in the canadian document Achieving Health for All: A Framework in Health Promotion which I released in November, 1986 at the first international conference on health promotion held in Ottawa.

The spirit of that document expresses health in terms of the degree to which people can realize their aspirations, cope with their environment and re-shape their living conditions to better suit their needs. Health is seen as a positive resource, a means to meet the needs of the individual and the interests of the community.

This definition suggests that health policy must expand beyond the boundaries of health care system policy - policy that is, in turn, dominated by issues of medical care. The focus shifts - from mortality and morbidity statistics to a concern for housing, education, food and quality of life; from elaborate medical treatment systems to promotion, prevention and primary care; from insular planning to intersectoral action; from top-down control to bottom-up involvement.

Bottom-up involvement is the idea embodied in the concept of public participation. An idea that is central to the "achieving health for all" movement and the declaration of Alma Ata. It is also one of three major implementation strategies suggested in the Canadian framework document.

Public participation reminds us that the ultimate credibility of achieving health for all lies in following up and supporting involvement at the most basic levels of families, neighborhoods and communities. This, in turn, will require a reallocation of power so that communities, have-not citizens and legitimate interest groups can be included in the determination of how resources are allocated, how information is shared and how policies are set.

Governments and the private sector foster public participation when they provide fiscal or professional support to mutual aid organizations and voluntary groups. In Canada, it is estimated that one person in four volunteers in activities such as education, health and social development. Their human capacity to share, to care and to innovate is strengthened by partnerships with all of the various governments in Canada.

At the national level, my department's recent commitments to community-based projects in AIDS, seniors' independence, drugs, health needs and regionally-defined needs amount to 42 million dollars this year alone.

In addition, my department grants some 6.5 Million dollars annually to national voluntary health and social service organizations to sustain the operation of their national offices.

For some time now, the federal government has also fostered and supported the increased involvement of our native population in addressing the health issues that affect them.

This year, native bands and tribal councils will receive grants in the order of 61 million dollars for community-based and managed health services and projects related to the prevention and treatment of alcohol and drug abuse - this in addition to the health services currently provided by the federal government through my department. At the same time, native bands and organizations will receive some 3 million dollars this year to assist them in preparing for the transfer of health services to increased local control.

I might add that Health and Welfare Canada and the Canadian government are committed to these programs over the long term.

Public participation is nurtured by accurate and timely information that helps people make appropriate choices about their health. In the developing world, for example, it is well known that the major threats to children's lives can be defeated, in large measure, by informing and supporting parents in actions such as breast feeding, oral therapy for diarrhoeal disease, birth planning, home hygiene and safety, and immunization.

While speaking of immunization I would like to take a moment to highlight a Canadian initiative called A Miracle in the Making. It is a project that Brock Chisholm, the visionary who called for the eradication of smallpox long before it was fashionable, would have been proud of.

A Miracle in the Making is Canada's international immunization program. It is financed by an allocation of 43 million dollars from the Canadian government and some 10 million dollars from our 16 non-governmental partners. The project is managed by the Canadian Public Health Association, who work in cooperation with WHO and Unicef on some 65 projects in 42 countries. It is a massive effort that is, in itself, a consummate example of public participation and partnership.

And it is working:

- By the end of 1986 immunization had reached 33 per cent of African children, with 20 African states exceeding 50 per cent.

- Some caribbean countries have now reached nearly 100 per cent immunization coverage, and a significant number are increasing 1990 targets to 90 per cent coverage or higher.

Because of programs like this one, I am informed that we have good reason to believe that global immunization can and will eradicate polio from the face of the earth by the year 2000.

This is a major cause for celebration.

It is not, however, a call for complacency. We must continuously remind ourselves that our joint efforts in health promotion and disease prevention must be sustained. In doing so, it becomes increasingly clear that essential public health measures like immunization are not only important because they prevent disease. They also provide an entry point to primary health care and community participation in health.

In a fortunate country such as Canada, this focus on community is expressed in our second major strategy - that of strengthening community health services.

The "achieving health for all" framework calls for the role of community health services to be expanded and expressly oriented toward promoting health and preventing disease. With a larger share of resources, Canadian community services will assume an even greater role in fostering self-care, mutual aid and the creation of healthy environments.

Particularly important is the role community health services and voluntary agencies can play in helping people to cope with disability. Community services are the most appropriate vehicle for providing a flexible continuum of support -- whether temporary or long term -- to enable people to meet their needs for assistance without disruptive and disorienting moves or institutionalization.

The third strategy in the health promotion framework is healthy public policy -- an intriguing concept that was the topic of the Second International Conference on Health Promotion, held in Australia a few weeks ago.

Healthy public policy is concerned with extending responsibility for health to policy and decision makers in all sectors, at all levels. It provides a means to seek diverse and complementary approaches to creating more equitable access to health through intersectoral cooperation in measures as diverse as taxation and organizational changes.

Accordingly, in Canada, we have increased our efforts to work with other departments, with other levels of government, with the professional and non-profit sector, and with private industry. Together, we are taking co-ordinated action on issues such as child care, drug abuse, tobacco advertising, family violence, native health services, heart health and impaired driving.

Two emerging initiatives in healthy public policy deserve particular note.

The first of these is healthy cities....An exciting idea that originated in Toronto as a project co-ordinated by the WHO health promotion office. It has since spread to some 12 cities in Canada, 2 cities in Australia and over 30 cities in Europe.

The project aims to develop cities which are both healthy and health promoting through policies at the municipal level not only in the area of public health, but also housing, transportation, urban design, waste management, and parks and recreation. In my view this kind of approach represents a basic shift in policy making. It is a transition that will lead us from vertical structures to networks and from parochial viewpoints to global thinking, while recognizing that healthy public policy usually works best at the local level.

A second emerging issue for policy consideration is the area of mental health.

If we truly believe, as Brock Chisholm did, that health involves the total person, we must acknowledge that mental life - thought, emotion, choice, communication, the creation of meaning - lies at the heart of all human life.

And so, my department, in co-operation with voluntary and professional sectors, is in the process of developing a policy that defines mental health as more than the absence of mental disorder. It seeks to relate the promotion of mental health to such basic principles as human rights, voluntarism, citizenship, professionalism, community development and empowerment.

These, ladies and gentlemen, are some of the issues and strategies that compel us today. What of the future?

As I reflect upon the past 40 years and endeavour to anticipate what lies ahead, I remain confident that Brock Chisholm's view of health and our own emerging understanding of health promotion will provide the vision we need to take us to the year 2000 and beyond.

It was on Dr. Chisholm's insistence that the word "world" rather than "international" was incorporated into WHO's name. His conception of a global organization, rather than one "between nations", has never been more important than it is today.

We are moving towards a multipolar world, a world that must celebrate its diversity while negotiating a more equitable order on a global scale. This will require collaboration and policy action on several fronts: alleviating the world food problem, revitalizing global financing and trading systems, reducing the threat of war, realizing the principles of human rights, protecting the environment, and recognizing the major role that women have to play in achieving health for all.

We are moving into the information age. With it comes the opportunity and communications capacity to put the knowledge people need to be healthy at the disposal of the great majority of the world's people.

We will witness major breakthroughs in genetics, transplantation, bionics, laser surgery and other medical sciences. And we will agonize over the ethical questions the new technologies pose.

Migration and immigration will continue to expand the world's cities and enhance their diversity. Led by the social movements of the day, values about non-salaried work and the conservation of the earth's resources will shift dramatically.

These many changes will add up to a broad transformation in all our lives. It is our job to listen, to promote the debate and to encourage healthy public policy initiatives that will guide these changes for the common good.

In this precarious environment of both risk and opportunity, leaders have an even greater responsibility to communicate the message that now, more than ever before, "spaceship earth" requires international cooperation in research and development activities like those promoted by the WHO. No technology is going to save us by itself, outside the context of our values and our choices. There is no automatic new paradigm that will carry us miraculously forward unless we purposely engage ourselves in change. Yet the problems inherent in the politics of health can be solved, if we can find the wit, the will and the courage to face them.

Brock Chisholm believed that people have a responsibility to work towards a future "when we can live together in understanding, tolerance and compassion, in the hope that we may be able - enough of us - to love our neighbor no matter what race, religion, skin colour, ideology or social group."

If we are willing to assume a futuristic outlook; if we are willing to celebrate diversity in a unified, pluralistic world; if we have the vision and tenacity to formulate and implement public policies that promote health, we will make a difference.

Thank you.